CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

RECOMMENDATION FROM CHIEF OF STAFF OR CHIEF OF SERVICE

Arrange for the Board office to receive this form from the Chief of Staff or Chief of Service in a medical facility where the Physician applicant currently or previously had privileges.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.

Last Name:_____ First:_____ Middle: _____

SSN:_____ DOB:_____ Other Name(s) Used: _____

Applicant Signature: _____ Date: _____

Evaluation to be completed by Chief of Staff or Chief of Service

Complete all items.

Check your evaluation of each element. Base evaluation on your personal knowledge or records maintained by your hospital.

Element	Unable to Evaluate	Below Average	Average	Above Average
Basic Medical Knowledge	☐	☐	☐	☐
Professional Judgment	☐	☐	☐	☐
Sense of Responsibility	☐	☐	☐	☐
Clinical Skills	☐	☐	☐	☐
Technical Skills	☐	☐	☐	☐
Cooperativeness, Ability to Work with Others	☐	☐	☐	☐
Medical Record Currency	☐	☐	☐	☐
Quality of Medical Records	☐	☐	☐	☐
Patient Management	☐	☐	☐	☐
Physician – Patient Relationship	☐	☐	☐	☐
Overall Performance	☐	☐	☐	☐

If you responded "Unable to Evaluate" or "Below Average" on any item, explain why on a separate sheet.

Unusual Circumstances to be completed by Chief of Staff or Chief of Service

Complete all items.

1. Was this applicant ever placed on probation? Yes ☐ No ☐
2. Was this applicant ever disciplined or placed under investigation? Yes ☐ No ☐
3. Were any limitations or special restrictions placed on this applicant due to questions of academic incompetence, disciplinary problems or any other reason? Yes ☐ No ☐

Explain *yes* answers and any other unusual circumstances on a separate sheet.

CERTIFICATION

AFFIX

INSTITUTION

OR NOTARY

SEAL HERE

I am licensed in the State of _____. I have known the applicant personally or professionally for the period (month/year)_____ to (month/year) _____.

☐ I recommend this applicant for licensure to practice medicine and surgery without reservation.
☐ I recommend this applicant for licensure to practice medicine and surgery with reservation.
☐ I **do not recommend this applicant for licensure** or to practice medicine and surgery.

Print Name of Institution Official: _____ **Title:**_____

Signature of Official: _____ **Date:** _____

Phone: _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**

Revised 5/2009